

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/10/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185210	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  07/29/2010
NAME OF PROVIDER OR SUPPLIER  THE JAMES B. HAGGIN MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 464 LINDEN AVENUE HARRODSBURG, KY 40330		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>A Standard Recertification Survey was initiated on 07/27/10 and concluded on 07/29/10 with no deficiencies cited. A Life Safety Code Survey was conducted on 07/28/10 with deficiencies cited. The highest Scope and Severity cited was an "E".</p>	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185210	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  07/28/2010
NAME OF PROVIDER OR SUPPLIER  THE JAMES B. HAGGIN MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 464 LINDEN AVENUE HARRODSBURG, KY 40330	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS  A Life Safety Code survey was initiated and concluded on 07/28/2010. The facility was found to not meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest scope and severity deficiency identified was an "E".	K 000	SEE ATTACHED	
K 073 SS-E	NFPA 101 LIFE SAFETY CODE STANDARD  No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure that decorations used in the facility were flame-retardant according to NFPA standards.  The findings include: Observation on 07/28/10 at 12:09 PM, revealed the facility had decorations throughout the facility that were not flame-retardant. The observation was confirmed with the Maintenance Director at the time of discovery. Interview on 07/28/10 at 12:09 PM, with the Maintenance Director, revealed that the facility did not have a policy or procedure for treating the decorations to make the decorations flame-retardant.	K 073		

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TITLE

(X6) DATE

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**PLAN OF CORRECTION  
THE JAMES B. HAGGIN MEMORIAL HOSPITAL  
EXTENDED CARE FACILITY  
SURVEY COMPLETION DATE 7/29/2010**

**NFPA 101 LIFE SAFETY CODE STANDARD**

**K 073 (SS=E)**

**Corrective Action For Residents Found To Have Been Affected By The Deficient Practice:**

No Residents were directly affected but the potential was there. The facility will have no furnishings or decorations of highly flammable character used. The Director of Physical Plant and Extended Care Coordinator removed all the highly flammable furnishings from Resident room doors as identified by the Life Safety Code Inspector on July 28, 2010.

**The Facility Will Identify Other Residents Having The Potential To Be Affected By The Same Deficient Practice:**

No Residents were directly affected but the potential was there. The facility will have no furnishings or decorations of highly flammable character used. The Director of Physical Plant and Extended Care Coordinator removed all the highly flammable furnishings from Resident room doors as identified by the Life Safety Code Inspector on July 28, 2010.

**Measures To Be Put In Place Or Systemic Changes Made To Ensure The Deficient Practices Will Not Recur:**

All visiting groups, current and resident POAs will be given written guidelines which will include a statement about not bringing flammable materials into the Extended Care Facility. All future furnishings, requested to be brought in, will be sprayed with an approved fire retardant before being used and inspected by the Director of Physical Plant or designee. If the request occurs on a night or weekend the Night/Weekend Nurse Coordinator will refer the requester to the Physical Plant Director or Extended Care Coordinator to be contacted the next business day.

The Director of Physical Plant and the Extended Care Coordinator or designee will perform weekly inspections to insure compliance.



CE 8/18/10

**How The Facility Plans To Monitor Its Performance To Ensure Solutions Are Sustained:**

Compliance will be reported to the Safety Committee bi-monthly by the Extended Care Coordinator.

Completion Date: ~~July 29, 2010~~

Aug 19, 2010

*[Signature]* 8/19/10